



Investment & Financial Services Association Ltd

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10 April 2007

Insurance Contracts Act Review
Corporations and Financial Services Division
The Treasury
Langton Crescent
PARKES ACT 2600

By email: icareview@treasury.gov.au

Dear Sir,

Draft Insurance Contracts Act 1984 Reform Package – Section 54

The Investment and Financial Services Association is pleased to provide this supplementary submission which specifically addresses section 54, Insurance Contracts Act and the impact it has on group life insurance.

In IFSA's submission to the Review Panel of 17 October 2003 we supported the retention of s54 given the benefit to consumers.

Notwithstanding IFSA's support we did express concerns in relation to the;

- determination of prejudice
- determination of the value to be attributed to prejudice, and
- late notification of claims for life products, especially group insurance.

IFSA submits that life insurance is different to general insurance and this has been recognised by the Review Panel in many of the recommendations made. With this distinction in mind the annexure to the letter sets out IFSA's reasoning for a balanced reform of this area of the law.

Please contact either myself or David Micó on 02 9299 3022, if you wish to discuss the contents of this submission or arrange a meeting.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Richard Gilbert', is written over a thin red vertical line.

Richard Gilbert
Chief Executive Officer

ANNEXURE

INSURANCE CONTRACTS ACT 1984 - THE OPERATION OF SECTION 54

It is IFSA's view that issues arising in the life insurance arena are different to those in general insurance. In particular, the assessability of life claims has a different character to that of general insurance. We consider that this raises a number of unique challenges for insurers and consumers which warrant an amendment to section 54.

Primarily these challenges arise from the difficulty in assessing retrospective claims. Where these claims relate to conditions insurable under a typical life policy there can be difficulties establishing the facts

As distinct from general insurance, where claims can be self-evident, life claims often rely upon a considerable amount of expert evidence from medical practitioners and other consultants. Indeed, claims lodged by consumers in relation to a range of conditions require medical assessment to verify the validity of a claim.

In normal circumstances claimant and insurer are likely to have access, or indeed custody, of case notes outlining the assessment. Where a condition is confirmed and the condition falls within the terms of the policy this is a relatively straightforward process and the claim is paid.

Where claims are made a considerable time after an event or condition arises, it can be difficult, if not impossible for information to be obtained. This leads to obvious difficulties and complexities for insurers, with resultant delays for consumers.

For example, historical claims can be encumbered by difficulties in recalling past medical practitioners and diagnosis, changes in practice ownership and population mobility.

Furthermore, insurers are often unable to conduct an independent assessment of an insured's condition if that condition is no longer prevalent or there is a risk that other factors may have since contributed to a claimant's condition.

In addition, the nature of some insurable risks is such that events can be temporal in nature. A retrospective claim in relation to a past condition is, again, very difficult for life insurers to verify.

We consider that insurers find that the nature of group life insurance claims lodged many years after an accident cause significant challenges for both insurers and insured consumers. We also consider that unlimited claim period increase the prospect of dispute.

In particular, the late notification of claims – in some cases many years after an accident – causes significant problems in assessing claims and considering, if any, the extent of prejudice involved.

The effect of this leads to adverse outcomes for both insurers and consumers. Insurers are subject to increased administration costs in the discovery and assessment process. Consumers can be faced with assessment delays and complexity due to the inherent difficulty in recalling past events and the challenges associated with retrieving historical records.

IFSA submit that there is an opportunity for government to reduce the cost and adversity – impacting on life insurers and insured consumers – in the context of the reforms being made to section 54. We offer further comments below which highlight some of the cases and claims experience which support this position.

1. Determination of Prejudice under section 54(1)

In *Moltoni Corporation v QBE Insurance* [2001] HCA 73 the High Court found that in considering prejudice under section 54(1), the court will look at actual financial damage that has been or will be sustained as a result of the relevant act or omission.

Putting the test at this level creates enormous difficulties for life insurers. Section 54(1) speaks of the “insurer’s interests” being prejudiced. In IFSA’s view the insurer’s interests may be prejudiced by various factors, which are discussed below. It is often not possible to put a quantified figure on that prejudice.

2. Determination of the Value to be attributed to Prejudice

a) Late Notification of Claims in Group Insurance

i) Percentage examples by year reported

One of our members has provided the following information on Total Permanent Disablement (“TPD”) claims.

For TPD claims notified in any given year the table below sets out the distribution of years in which group insurance claims were actually incurred and notified over a four year period.

The pattern of claims being notified on any individual fund may be slower or faster than that set out below. Delays in the reporting of claims from industry funds are generally longer than those exhibited by single employer corporate superannuation arrangements.

Year zero means the claim was incurred in the same calendar year it was reported, 1 means the year prior to that.

Year Incurred = x years before the calendar year notified where x is	Distribution of claims reported by Year Incurred
0	17%
1	40%
2	20%
3	9%
4	6%
5-9	7.5%
10+	0.5%

The above is based on claims experience of 1200-1300 TPD claims being reported each year. As an example the above indicates that 40% of TPD claims reported in 2002 were for claims incurred in 2001 but more importantly around a quarter (23%) of TPD claims notified in 2002 were incurred in 1999 or earlier. Indeed the above indicates that 8% or 1 in 12 TPD claims notified in 2002 are from 1997 or before, i.e. the claim has been notified 5 or more years after the insured is actually claiming to have become TPD.

The effects of late notification are significant in a number of respects. A primary concern is the policy reserves that were set aside to meet a claim no longer being available to meet late notified claims. As group insurance policies move from one life insurer to another every three to five years, how long must a life insurer or a reinsurer need to maintain reserves when the cover has ceased under a group insurance policy or indeed a personal policy? Collation of medical evidence from 5 or more years ago, while often possible, is very difficult to find. Even if it is found there is little if any ability to get a second opinion on the extent of the disability at that time. The claimant may be TPD now but may not have been, for example, 7 years ago when the employee ceased work.

It is usually impossible for the insurer to say exactly what it would have done at the time the insured claims to have been TPD. It will often be extremely difficult to show how specific processes would have led to a quantifiable reduction in liability (following the Moltoni decision). For example, if the insured would have participated in a rehabilitation program, the insurer will have to seek expert evidence to show that this would have reduced the insurer's liability. Further, there may be evidence that could have been sought at the time of TPD but cannot at the time of claim (for example, witnesses cannot be located). The Moltoni decision has resulted in the insurer often being in an impossible position of being denied the opportunity to gather evidence and therefore being unable to show prejudice in the Moltoni sense.

ii) Specific case examples

- (1) This case highlights how prejudice can arise to an insurer through the delay in claim notification.

The member left work in 1992. The sickness which was the subject of the claim (and the alleged entitlement to TPD), was not diagnosed until 1995. The claim was lodged in 2000. The member claimed she had been TPD since 1992 but it was not until medical evidence was received in September 2002 that it was confirmed the member suffered from the claimed sickness. Given the delay in notification of the claim the doctor was not in a position to substantiate the permanence of the member's condition at the time of ceasing work.

This claim was lodged in October 2000, 8 years after the date for which the member claimed to have become TPD. In order for the insurer to make a complete assessment at the time of claim, it required a full factual assessment with the member / previous employer to determine details of the member's performance at the time, ability to carry out her assigned work duties etc. This can be extremely difficult to achieve even when it is sought at the time of claim. The longer the time between claim and notification, the more difficult this becomes for an insurer to obtain accurate information. The information obtained by the insurer during its assessment could not be used to determine total and permanent disablement in October 1992.

In this example, it was not medically established that the insured was TPD at the time she ceased working. Whilst the insurer would have been entitled to deny liability, (it was clearly prejudiced by the delay and the lack of clarity in the evidence, it felt forced to make a business decision to compromise the claim.

- (2) The member lodged a claim about 8 years after allegedly becoming TPD. The treating doctor's surgery had burned to the ground and all notes destroyed. The insurer was not able to fairly assess whether or not the member was TPD.

- (3) The member last worked in November 1993 and submitted a claim in April 2003. Originally the member had a hand injury but some time later developed a psychiatric condition. He had a motor car accident in early 2003. In these circumstances it is very difficult to apportion the causes of the disability. The member had also not kept Group Certificates for 1991 to 1997 so it was not possible to assess whether he had been working. Given the time elapsed there are often difficulties getting information from former employers.

- (4) In a further example from one of our members, acceptance of an employee as an insured under the employer's group income continuance policy was automatic if the employee was nominated as being an insured. Under the policy terms the nomination had to be made after the prospective insured had been an employee for six continuous months but before the seventh month commenced – a 30 day window in which to nominate applied. Under the policy, outside of this period the employee had to be individually underwritten.

The purpose of the restriction in the nomination time was to protect the insurer from a prospective insured nominating when a claim was imminent. It is arguable that s54 forgives the prospective insured's (or the employer policyholder's) omission to nominate the person within the one month window.

Potentially, any employee employed for 6 months or more can argue that they ought be insured even if they never nominated or their employer never nominated. If that is the effect of section 54 in such policies then it is an example of where section 54 may operate to stifle the utility of consumer friendly automatic acceptance terms. If that is so, insurers may have to reconsider whether automatic acceptance terms are commercially feasible or premiums must be increased to allow for cases where the law allows those to join when a claim is imminent as is arguably allowed by section 54 where automatic acceptance terms are offered. Both would be unfortunate outcomes for consumers.

b) Interaction with section 29

A claim notified late may cause a life insurer to lose the opportunity to make enquiries and avoid the policy within the prescribed period (3 years from the time the contract was entered into) under section 29(3). There will necessarily be occasions where it is evident that apart from the late notification, the insurer would have been able to avoid the policy and the insured would not have been able to make the claim under that policy. Alternatively, the insurer may be able to exercise its rights under section 29(4). Section 54 undermines the remedies available to the insurer under section 29 if the claim is notified late.

The proposals to amend s29 will remove this particular issue and is another reason that proposed s28A apply from Assent.

c) Limitation periods

A couple of recent cases (Cigna Insurance Asia Pacific Limited v Packer [2000] WASCA 415 and Tonkin v Western Mining Corporation Limited (1998) 10 ANZ Insurance Cases at 61) have considered the issue as to when a cause of action arises in a TPD claim. Where a TPD definition requires the formation of an opinion by the insurer or Trustee as to whether the insured is TPD, the cause of action arises at the time the opinion is formed. Where there is no requirement for an opinion, the cause of action arises once the insured satisfies the TPD definition. This creates significant problems for the insurer, as there is no limitation period to deter claims being brought to the insurer's attention years after an injury or disability occurs.

3. Proposed changes to Section 54

a) Section 54A

The Review recommends the introduction of a new section 54A. In IFSA's submission it would be appropriate to extend the recommended amendment to include group life insurance. There does not seem to IFSA to be any sensible reason why the recommended notification requirement on an insured under a "claims made" policy should not apply to insureds under group life insurance policies. If the insured is aware of circumstances that might give rise to a claim, he/she ought to be required to notify the insurer prior to expiration of the policy.

Group life insurance policies generally last 3 – 5 years. Requiring the insured to notify within the term of the policy would negate any problems in determining which insurer may be responsible for a claim. It would also mean that an insurer is able to provide for future claims, with an associated impact on premiums.

b) Section 54 and prejudice

In IFSA's submission the requirement for an insurer following the Moltoni decision, to show quantifiable prejudice, often leaves insurers with no remedy under section 54. We seek an amendment to section 54 to ensure that prejudice need not be precisely quantifiable in order to facilitate a quicker claims settlement process. IFSA consider that this amendment would benefit both insurers and consumers by reducing the amount of administration, complexity and delays for both parties.

4. "Claims made" policies

Life insurers have written "claims made" group policies in the past but it is IFSA's understanding that these policies are no longer used. On that basis, we offer no additional comment in relation to the impact on policies of this type.

Concluding comments

Given the above comments, IFSA submit that there is a strong case for imposing a reasonable statutory time limit on the notification of group life insurance claims.

This approach would be broadly consistent with some of the recent changes introduced by government to improve the availability and affordability of other products such as professional indemnity insurance.

The life insurance industry recognise that it is important to ensure we balance the interests of consumers who require effective flexible life insurance protection with an approach that recognises the unique difficulties in responding to long-dated group life insurance claims.